Consumer Council News

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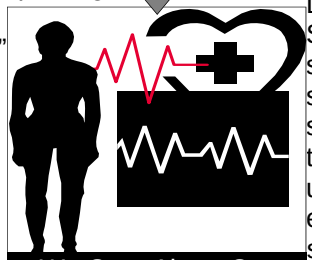
Inadequate National Mental Health/Substance Abuse Care

A report released by the Institute of Medicine (IoM) November 2005 showed that while effective treatment for mental health and substance abuse illnesses exist, there is a discrepancy between what care is effective and what care is actually delivered. The report, "Improving the Quality of Health Care for mental and Substance-Use Conditions," documents findings from a review of studies published between 1992 and 2000 assessing the quality of care for many different illnesses, including alcohol withdrawal, bipolar disorder, depression, panic disorder, psychosis, schizophrenia, and substance abuse. The review found that only 27 % of the studies reported adequate rates of adherence to established clinical practice guidelines. The report cites one review of the charts of 31 randomly selected patients in a state psychiatric hospital that detected 2,194 medication error during the patients' collective 1,448 inpatient days. Of the errors, 58% were judged to have the potential to cause severe harm. The recommendations were that the Department of Health and Human Services (HHS) would strengthen,, coordinate, and consolidate the synthesis and dissemination of evidence on effective mental health and substance use treatments and services and expand efforts to attain widespread evidence-based practices. This challenge to improve care will involve developing an electronic health record system.



We Care About Our Veterans

VA Co-Payments for Medicines to Rise

Co-payments for outpatient medicines prescribed through the Department of Veterans Affairs (VA) medical facilities will rise by $1. The increase to $8 from $7 for a 30-day supply of prescription drugs is required by federal law, which bases VA's co-payments for outpatient prescriptions on increases in the Medical Consumer Price Index.

This will not affect veterans who have an injury or illness connected with their military service resulting in a 50% or greater disability. The Priority Group 1 veterans will see no change to their current prescription drug benefit.

Other veterans with less pronounced service-connected ailments-those classified as Priority Groups 2 through 6-will see their prescription drug co-pays rise by $1, but their annual out-of-pocket expenses for VA medicine, which includes co pays, will remain capped. The cap will rise to $960 next year, up $120 from the previous level. This means veterans in Priority Groups 2 through 6 will pay no more than $960 annually for VA outpatient medicine.

Increases in the drug co-payment have been requested in the last several administrations VA budget proposals, but have historically been firmly and vociferously rebuked. There are no increases anticipated for the fiscal year 2007 budget.

National Center for PTSD

A *Guide for Families-"Returning from the War Zone"* has been produced by the National Center for PTSD (November 2005). This guide has been developed for military members and their families to help them adjust to changes during the return home from war. The guide is full of information for families to understand what to expect when returning from a war zone, and to help soldiers better adapt back to home life. This can be downloaded: **www.ncptsd.va.gov/topics/war.html**

Newsletter sponsored by VA Mental Health Consumer Council
FAX comments to Lucia Freedman at 202-273-9069 or call 202-273-8370

Online Newsletter
www.mentalhealth.med.va.gov/cc

VA Peer Support & Education Conference

The first VA peer support conference was held November 1-3, 2005. The conference consisted of participants from 45 VA sites or Vet Centers. The participants included veterans who are actively engaged in peer support services, VA staff who work as partners with peers, VA administrators and researchers, and non-VA community partners with expertise in peer support and recovery services. The following highlights of the conference include ideas from the discussions of those that attended:

* Peer support services are broad ranging in nature, varying with respect to the degree of staff or peer ownership and with respect to the degree to which services are supportive or more like traditional mental health treatments.
* In many VA programs, peer support has evolved from initial stages involving higher levels of professional guidance and input to later stages largely overseen by peers, with professional staff providing as needed consultation.
* It is important to identify a lead peer facilitator/peer specialist to manage the interface between peers and staff.
* Training is extremely important especially in confidentiality issues, conflict management, dealing with difficult personality qualities and managing acute symptoms in a group setting.
* There is a wide range of peer support services outside the VA which can help inform us about the possibilities for future programming.
* Clarity about expected roles and how accountability is determine for peer specialists is a key issue for successful implementation
* The power in a system that embraces peer support, are consumers providers and professionals working together to enhance services. In such a system neither role is diminished but consumer provider are well integrated on to the team.

Growing Mental Health Intensive Case Management Services in Rural Areas

The Veterans Health Administration (VHA) Strategic plan for Mental Health Services (July 2004) called for the development of a strategy to ensure that veterans in rural areas have access to mental health care. A work group comprised of representatives from VHA Mental Health Intensive Case Management (MHICM) teams, Community Agencies and VHACO came up with draft standards for community-based services in rural and small market settings where a full MHICM team is not feasible. Although the standards are not yet final, we summarize them here. The initiative targets areas with 14-59 veterans who have serious mental illness. Units of 2 or 3 clinicians with psychiatric and administrative back-up would provide services to veterans within an accessible driving distance of their offices. Each unit would be linked with an established full MHICM team for administrative and clinical planning, support and training. Linked teams would share case reviews and communicate regularly through teleconferences and occasional face-to-face meetings. The rural MHICM teams might be based in community-based outpatient clinics, small hospitals, or other community settings. Veterans served would receive:(1) Face-to-face contact in community setrtings;(2) Telephone contact to supplement face-to-face visits;(3) Medication adherence assistance; and(4) Coordination of health care needs via advocacy, education etc. Other services would be provided as feasible such as skills training; Family education; Supported employment; Crisis planning and intervention. It is expected that there would be two to three contacts per week, with a least one face-to-face. This will increase access

Information and Resources

Vet-to-Vet DVD
Peer Program for veterans
Get a copy: Patricia.Crann@med.VA.gov

SAMHSA National Conference on Returning Veterans
March 16-18, 2006
Washington, DC
Contact: Andrea Vincent-1-866 277-4772